2019 IHCP
2nd Quarter Workshop

A joint presentation on MCE policies and processes.

MCE Portals

Eligibility

Prior Authorizations

Claims

Provider Maintenance

Gateway to Work

Resources


Anthem
BlueCross BlueShield

CareSource

MDwise
A McLaren Company

mhs

MCE Portals

MCE Portals

- Anthem – via Availity
- CareSource
- Managed Health Services
- MDwise

Through the MCE portals providers can:

- Enroll, disenroll, and update primary medical providers
- Review their encounter claims
- Inquire on a managed care member's eligibility

MCE Portals

Availity is a secure multi-health plan portal that will get you the information you need instantly. It can be accessed at www.availity.com and used to do the following:

- Eligibility and Benefits Inquiry
- Claim Submission and Inquiry
- Patient Care Summaries
- Care Reminders
- Online Remittances
- Request Prior Authorization through the Interactive Care Reviewer (ICR)
- Obtain status of an Authorization request through the ICR.

MCE Portals

CareSource®

The CareSource Provider Portal allows providers to save money and time.

Providers can access the following:

- Verify Member Eligibility
- Provider Membership Lists
- Clinical Practice Registry
- Provider Grievance
- Provider Appeals
- Submit Claims
- Claim Recovery Request
- Care Management Referral
- Provider Maintenance

MCE Portals

MDwise
A McLaren Company

The myMDwise Provider Portal allows registered providers to:

- View member eligibility information.
- View member claims information.
- View member PMP information.
- View PMP patient rosters.
- Submit requests to Care Management/Disease Management programs.
- Request access to Quality Reports.
- Request access to Member Health Profiles.
- Contact MDwise Provider Relations securely online.

MCE Portals

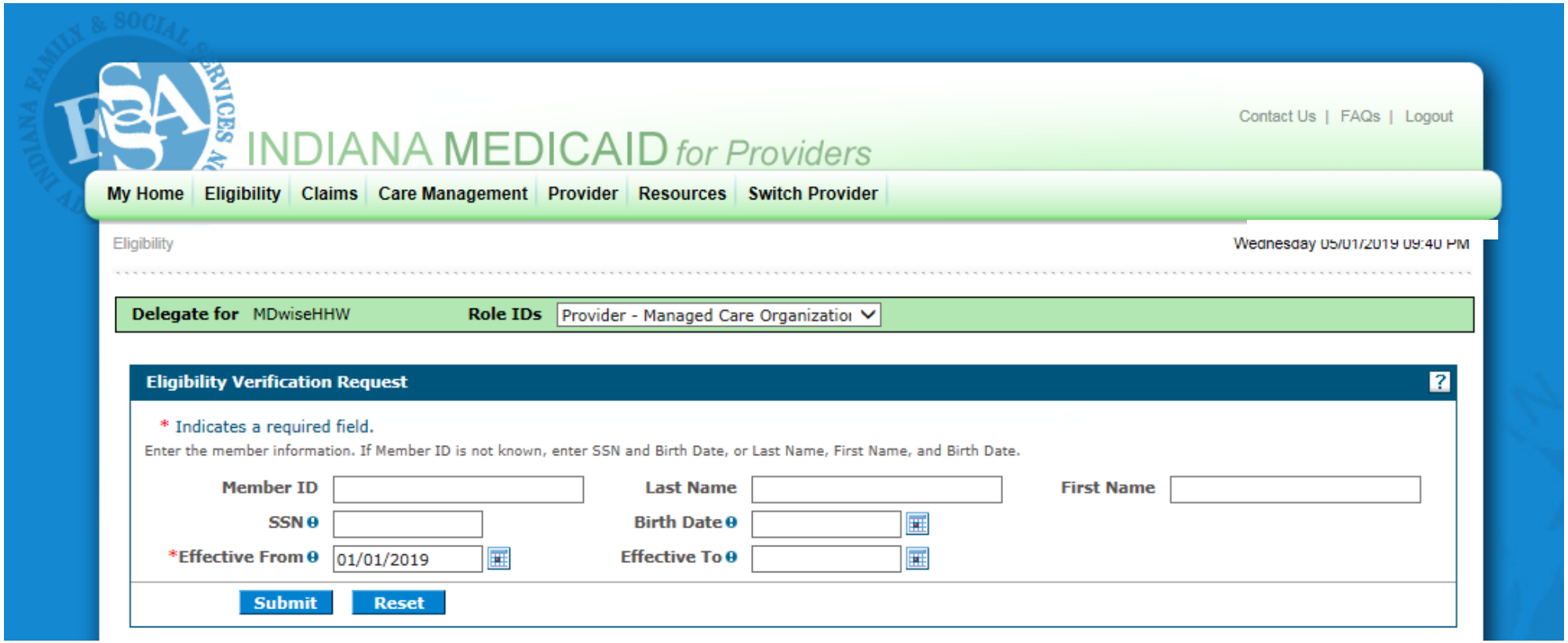
Providers may register at mhsindiana.com to access MHS' Secure Provider Portal, where they can:

- Manage multiple practices under one account
- Check member eligibility
- View member panels
- View medical history and gaps in care
- Submit/check authorizations
- Submit/check/adjust claims
- View HEDIS Pay for Performance Reports
- Access explanation of payments
- Communicate electronically with MHS, with one business day response time
- Access electronic copies of manuals, presentations, training material and various forms
- Access free online health library with click & print patient education material

Eligibility

Eligibility

Member eligibility can be confirmed using the IHCP Provider Healthcare Portal or the MCE provider portals.



Eligibility

Retro-eligibility

- Member eligibility categories may be established retroactively up to 3 months prior to the member's date of application, if the member met eligibility requirements in each of those retroactive months.
- When notified of member's retroactive eligibility, the provider must refund to the member any payments made by the member for covered services rendered on or after the member's eligibility effective date.
- If the service was rendered more than 1 year ago and is past the filing limit, the provider must submit a claim with appropriate documentation requesting a filing limit waiver.

Eligibility

Retro-authorization

- If prior authorization (PA) is required for the covered service, such authorization may be requested retroactively up to 1 year from the date the member was enrolled.
  - Provider must indicate “retroactive eligibility” on the authorization request form.

Dates of Service Start	Stop	Procedure/ Service Codes	Modifiers		Service Description	Taxonomy	Place of Service (POS)	Units	Dollars
1/1/19	1/1/19	E0193			Heel Protector			2	$2500.00

Notes: RETROACTIVE ELIGIBILITY

PLEASE NOTE: Your request MUST include medical documentation to be reviewed for medical necessity.

Eligibility

Retro-authorization for Fast Track HIP members

- After the provider assists with the application for health coverage, they must complete a Fast Track Notification Form and fax to the MCE selected on the application.
  - This process must be completed within 5 days of the date of admission.
- After eligibility has been established, the MCE will return a Full Eligibility Notification Form to the provider via fax. This form will contain the member's MCE assignment and RID.
  - The notification will occur within 7 days following eligibility discovery.
- The provider will then be able to submit a PA request for the service rendered since the first day of the month of the Fast Track prepayment.
- Providers must verify eligibility and submit the PA request within 60 days of receiving the Full Eligibility Notification Form.

See BT201913 for more information on Fast Track

Eligibility

Notification of Pregnancy (NOP)

Providers may receive $60 for one NOP per managed care member, per pregnancy. The following requirements must be met for a provider to be eligible for reimbursement for submitting an NOP:

- The NOP must be submitted via the Portal no more than 5 calendar days from the date of the office visit on which the NOP is based.
- The member's pregnancy must be less than 30 weeks gestation at the time of the office visit on which the NOP is based.
- The member must be enrolled with a managed care entity (MCE), including pregnant women enrolled in an MCE through HIP, Hoosier Care Connect or Hoosier Healthwise, as well as presumptively eligible pregnant women enrolled with an MCE.
- The NOP cannot be a duplicate of a previously submitted NOP.

NOP Form and additional information: https://www.in.gov/medicaid/providers/480.htm

Prior Authorization

Prior Authorization

Who determines it?

- The MCE must operate and maintain its own prior authorization requirements.
- The MCE may limit coverage based on medical necessity or utilization control criteria, provided the services furnished can reasonably be expected to achieve their purpose.
- The MCE is prohibited from arbitrarily denying or reducing the amount, duration, or scope of required services, solely because of diagnosis, type of illness, or condition.
- Remember, prior authorization is not a guarantee of payment but an authorization for the rendering of service(s).

Prior Authorization

What is it?

- The MCE may accept a nationally recognized set of guidelines, including but not limited to Milliman Care Guidelines.
- Additional considerations:
  - ASAM
  - IAC (Indiana Administrative Code)
  - Right Choices Program
  - Clinical Guidance
  - DUR Board
  - Medicaid Contract
  - IHCP Provider Reference Modules
  - IHCP Bulletins and Banners

Prior Authorization

When *is* it needed?

- Inpatient care – *always*
- Continuation of emergent care
- Surgery
- Changes in level of care
- Non-contracted providers (Anthem, CareSource, MDwise)
- Right Choices Program

And more…

Prior Authorization

When is it *not* needed?

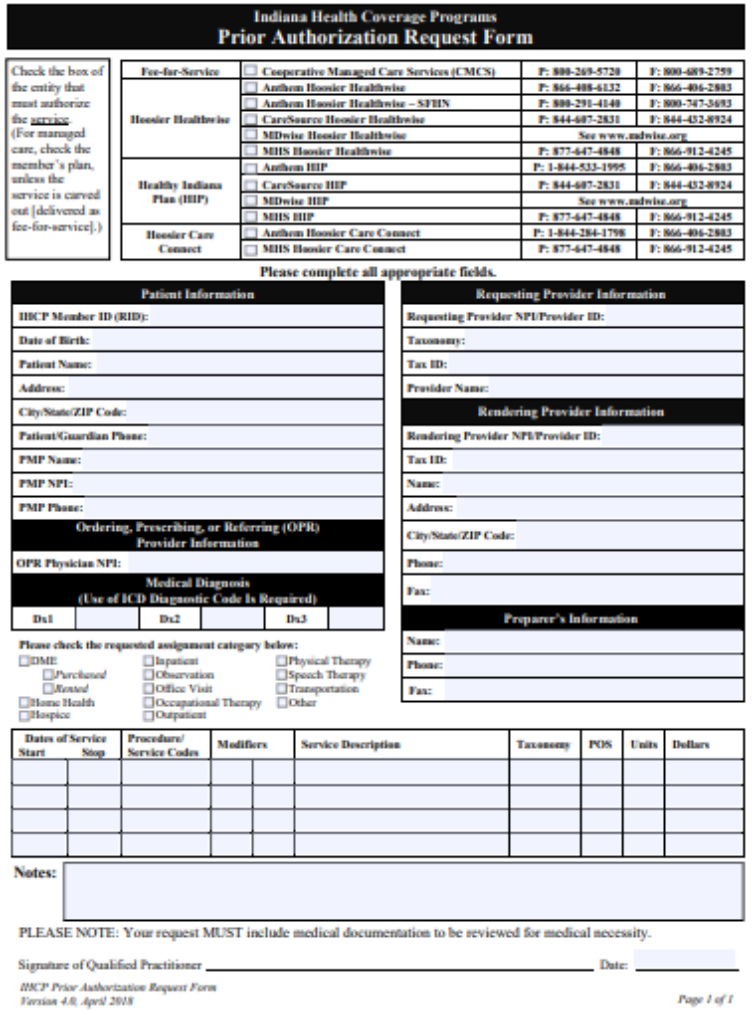
- Preventative services
- Self-referral services
- Emergencies
- Home health post-discharge
- Preferred drug list

And more…

Prior Authorization

What is needed?

- Completed Universal PA form
- Supporting documentation
- Contact information for the requestor
- Submission to the correct MCE



Indiana Health Coverage Programs
Prior Authorization Request Form

Check the box of the entity that must authorize the service. (For managed care, check the member's plan, unless the service is carved out [delivered as fee-for-service].)

Fee-for-Service	☐ Cooperative Managed Care Services (CMCS)	P: 800-269-5720	F: 800-689-2759
Hoosier Healthwise	☐ Anthem Hoosier Healthwise	P: 866-488-6132	F: 866-406-2803
	☐ Anthem Hoosier Healthwise – SFHN	P: 800-291-4140	F: 800-747-3693
	☐ CareSource Hoosier Healthwise	P: 844-687-2831	F: 844-432-8924
	☐ MDwise Hoosier Healthwise	See www.mdwise.org	
	☐ MHS Hoosier Healthwise	P: 877-647-4848	F: 866-912-4245
Healthy Indiana Plan (HIP)	☐ Anthem HIP	P: 1-844-533-1995	F: 866-406-2803
	☐ CareSource HIP	P: 844-687-2831	F: 844-432-8924
	☐ MDwise HIP	See www.mdwise.org	
	☐ MHS HIP	P: 877-647-4848	F: 866-912-4245
Hoosier Care Connect	☐ Anthem Hoosier Care Connect	P: 1-844-284-1798	F: 866-406-2803
	☐ MHS Hoosier Care Connect	P: 877-647-4848	F: 866-912-4245

Please complete all appropriate fields.

Patient Information

IHCP Member ID (RID):
Date of Birth:
Patient Name:
Address:
City/State/ZIP Code:
Patient/Guardian Phone:
PMP Name:
PMP NPI:
PMP Phone:

Ordering, Prescribing, or Referring (OPR) Provider Information

OPR Physician NPI:

Medical Diagnosis (Use of ICD Diagnostic Code Is Required)

Dx1 | Dx2 | Dx3

Requesting Provider Information

Requesting Provider NPI/Provider ID:
Taxonomy:
Tax ID:
Provider Name:

Rendering Provider Information

Rendering Provider NPI/Provider ID:
Tax ID:
Name:
Address:
City/State/ZIP Code:
Phone:
Fax:

Preparer's Information

Name:
Phone:
Fax:

Please check the requested assignment category below:

☐ DME: ☐ *Purchased* ☐ *Rented*
☐ Home Health
☐ Hospice
☐ Inpatient
☐ Observation
☐ Office Visit
☐ Occupational Therapy
☐ Outpatient
☐ Physical Therapy
☐ Speech Therapy
☐ Transportation
☐ Other

Dates of Service Start	Stop	Procedure/ Service Codes	Modifiers		Service Description	Taxonomy	POS	Units	Dollars

Notes:

PLEASE NOTE: Your request MUST include medical documentation to be reviewed for medical necessity.

Signature of Qualified Practitioner _____ Date: _____

IHCP Prior Authorization Request Form
Version 4.0, April 2018

Page 1 of 1

Prior Authorization

Where is the information?

- Code of federal regulations (CFR)
- Indiana administrative code (IAC), 405 IAC 5-3
- www.IN.gov/medicaid
  - Banners, bulletins, medical policy manual, PA module, etc.
- MCE websites
  - Anthem: https://mediproviders.anthem.com/in/Pages/prior-authorization.aspx
  - CareSource: https://www.caresource.com/in/providers/provider-portal/prior-authorization/
  - MDwise: https://www.mdwise.org/for-providers/forms/prior-authorization
  - MHS: https://www.mhsindiana.com/providers/prior-authorization.html

Prior Authorization

Why have it?

- Care Management
- Disease Management
- Utilization of Services (under and over)
- Fraud, Waste, and Abuse (FWA)
- Quality of Care
- Health Outcomes
- Early Detection

Prior Authorization

What are the timelines?

- All elective inpatient/outpatient services must be prior authorized at least 2 business days prior to the date of service
- All urgent and emergent services must be called into MCE within 2 business days after the admit
- Previously approved prior authorizations can be updated for changes in dates of service or CPT/HCPCS codes within 30 days of the original date of service
- Remember: Prior Authorization Appeals must be initiated within **30 calendar days (60 for MHS, 33 for MDwise)** of the denial to be considered. Please note, this is different than a claim dispute, which must be requested within **60 calendar days (67 for MHS).**

Prior Authorization

Anthem BlueCross BlueShield

How do I submit?

- Prior Authorizations can be obtained by:
  - Going to www.availity.com and using the Interactive Care Reviewer (ICR) or by calling HHW 866-408-6132, HCC 844-284-1798 or HIP 844-284-1798.
  - Fax
    - Inpatient Physical Health: 888-209-7838
    - Inpatient Behavioral Health: 877-434-7578
    - Outpatient Physical Health: 866-406-2803
    - Outpatient Behavioral Health: 866-877-5229
  - Pharmacy PA fax 844-864-7860 for prescriptions and 888-209-7838 for Medical injectables

Prior Authorization

Anthem BlueCross BlueShield

How do I submit?

- Prior Authorization for Radiology, Sleep Studies and Outpatient Rehabilitative and Habilitative services
  - AIM Web Portal can be accessed via availity.com or https://providerportal.com/
  - Phone # 800-714-0040
- AIM Reconsideration
  - AIM will accept reconsideration review at 800-714-0040 or via the portal up to 10 business days from the denial decision date.

Prior Authorization

CareSource

How do I submit?

- Prior Authorizations can be obtained by:
  - Email: inmedmgt@caresource.com
  - Phone: 1-844-607-2831
  - Fax: 1-844-432-8924
  - Mail:

    CareSource
    Attn: IN Utilization Management
    P.O. Box 44493
    Indianapolis, 46244

Prior Authorization

CareSource partners with NIA Magellan to implement a radiology benefit management program for outpatient advanced imaging services.

NIA Magellan Imaging

Procedures requiring prior authorization through NIA Magellan:	Services NOT requiring prior authorization through NIA Magellan:	NIA Magellan authorization phone number:
• CT/CTA • MRI/MRA • PET Scans • Myocardial Perfusion Imaging (MPI) • MUGA Scan • Echocardiography • Stress Echocardiography	• Inpatient advanced imaging services • Observation setting advanced imaging services • Emergency room imaging services	• 1-800-424-4883

Authorizations are accepted at https://www1.radmd.com/radmd-home.aspx .

Authorization requests are approved at intake in most cases. If an approval cannot be issued during the initial intake, more information may be required.

Note: Imaging procedures performed during an inpatient admission, hospital observation stay or emergency room visit are not included in this program.

Prior Authorization

MDwise
A McLaren Company

How do I submit?

- Prior Authorizations can be obtained by:
  - Fax
    - Hoosier Healthwise: 1-888-465-5581
    - Healthy Indiana Plan Inpatient: 1-866-613-1631
    - Healthy Indiana Plan Outpatient: 1-866-613-1642
- Questions regarding a PA submission?
  - Call: 1-888-961-3100

Prior Authorization

How do I submit?

- Check to see if a pre-authorization is necessary by using our online tool located on the sidebar. It's quick and easy. If an authorization is needed, you can:
  - Phone: 1-877-647-4848
  - Fax: 1-866-912-4245
  - Online: Provider Portal
- Questions regarding a PA submission?
  - Call: 1-877-647-4848

Prior Authorization

How do I submit?

- MHS partners with NIA for the outpatient Radiology and physical medicine services (physical therapy, occupational therapy and speech therapy) PA Process*.
- PA requests must be submitted via:
  - Electronic
    - NIA Web site at www.RadMD.com
  - Phone: 1-866-904-5096

*Not applicable for ER and Observation requests

Prior Authorization

How do I submit?

- Durable & Home Medical Equipment requests should be initiated via MHS secure portal.
  - Simply go to www.mhsindiana.com , log into the provider portal, and click on “Create Authorization.” Click DME and you will be directed to the Medline portal for order entry.
- Fax: 1-866-346-0911
- Phone: 1-844-218-4932

Prior Authorization

How do I appeal?

- Remember: Prior Authorization Appeals must be initiated within **30 calendar days (60 for MHS, 33 for MDwise)** of the denial to be considered. Please note, this is different than a claim dispute, which must be requested within **60 calendar days (67 for MHS).**
- MCE will acknowledge an appeal was received within **3 business days.**
- MCE will send decision letter within **5 business days** of the clinical decision/determination.
- Peer-to-Peer review is also available.

Prior Authorization

Anthem BlueCross BlueShield

How do I appeal?

- Prior Authorizations can be appealed by:
  - Fax: 1-855-535-7445
  - Mail:

    Anthem Blue Cross and Blue Shield
    Provider Disputes and Appeals
    P.O. Box 61599
    Virginia Beach, VA 23466
  - Expedited PA Appeals: 1-855-516-1083

Prior Authorization

Anthem BlueCross BlueShield

How do I appeal?

- Peer to Peer Review
- By Phone @ 866-902-4628 opt 1.
  - Peer to Peer requires 3 dates and times for follow up.
  - Note this can be found in the Anthem Reconsideration Process found at Anthem.com/inmedicaiddoc

Prior Authorization

CareSource

How do I appeal?

- Prior Authorizations can be appealed by:
  - Phone: 1-844-607-2831
  - Fax: 1-844-417-6262
  - Paper
    - Provider Clinical Appeal Form
    - https://www.caresource.com/documents/in-med-provider-clinicalclaim-appeal-form/
- Clinical Peer Review
  - Call: 1-844-607-2831, extension 12830

Prior Authorization

MDwise
A McLaren Company

How do I appeal?

- Prior Authorizations can be appealed by:
  - Mail

    MDwise Customer Service Department
    Attn: Appeals
    P.O. Box 441423
    Indianapolis, IN 46244-1426
  - Phone: 1-800-356-1204
- If you have any questions regarding this denial decision or would like to discuss the denial decision with the Physician Reviewer, which is a peer review, please call our Medical Management Department at 1-800-356-1204.

Prior Authorization

How do I appeal?

- Prior Authorizations can be appealed by:
  - Mail:
    Managed Health Services
    Attn: Appeals Coordinator
    P.O. Box 441567
    Indianapolis, IN 46244
- Providers must initiate appeals within 60 days of the receipt of the denial letter for MHS to consider.
- Additional Information found in the MHS Provider Manual

Prior Authorization

How do I initiate peer-to-peer review?

- Practitioners who disagree with a determination based on medical necessity may request a peer-to-peer review within 10 calendar days of the denial.
- The provider must contact MHS Appeals and provide three available dates and times to schedule a personal discussion with the MHS Medical Director or Pharmacist reviewer who rendered the determination.
- Providers may contact MHS Appeals at 1-877-647-4848, extension 87058 to leave a voice mail with their availability.

Claims

Claims

Claim Submission

Timelines:

- Contracted or In-Network providers: 90 calendar days from the date of service or discharge date.
- Other insurance as primary: 90 days from the date of the primary remit
- Non-Contracted or Out-of-Network providers: 180 calendar days from the date of service or discharge date

Exceptions:

- Newborns: Services rendered within the first 30 days of life have a 365 day timely filing limit.
- Other insurance as primary Insurance

Claims

Billing requirements for *CMS-1500*:

- Box 24J: rendering provider NPI
- Box 33: group/billing provider's **service** location on file with IHCP-complete address with complete 9-digit zip code (**no PO Box or remit address**)
- Box 33A: group billing provider NPI
- Box 33B: group billing taxonomy code

Note: The National Provider Identifier (NPI) number, Tax Identification Number (TIN) and Taxonomy Code are ***required on all claims***.

- Note: Be sure you report all of your NPI numbers and taxonomies with the State of Indiana at www.IN.gov/Medicaid.

Claims

Billing requirements for UB-04

- Box 1:billing provider **service** location name, address and expanded ZIP Code + 4
- Box 56: 10 digit NPI for the billing provider
- Box 81ccA: Billing taxonomy (required for Anthem)

Note: The National Provider Identifier (NPI) number, Tax Identification Number (TIN) and Taxonomy Code are ***required on all claims***.

- Note: Remember to attest all of your NPI numbers with the State of Indiana at www.IN.gov/Medicaid.

Claims

Claim Processing

Timelines:

- 21 days for electronic clean claims
- 30 days for paper clean claims
- Before you resubmit, check the claim status via the portals. If there is no record of the claim, resubmit.

Note: A “clean claim” is one in which all information required for processing the claim is present.

Claims

Anthem BlueCross BlueShield

Claim Submission for Medical and Behavioral Health

- Online through www.Availity.com
- Paper claims:
  Anthem Blue Cross and Blue Shield
  Attn: Claims
  Mail Stop: IN999
  P.O. Box 61010
  Virginia Beach, VA 23466
- Electronic submission:
  Professional Claims: 00630
  Facility Claims: 00130

Claims

CareSource

Claim Submission

- Online through the Provider Portal
- Paper claims:

  CareSource
  Attn: Claims Department
  P.O. Box 3607
  Dayton, OH 45401

- Electronic submission:

  CareSource payer ID number: **INCS1**

Claims

MDwise
A McLaren Company

Claim Submission for Medical and Behavioral Health

- Paper claims:
  MDwise/McLaren Health Plans
  P.O. Box 1575
  Flint, MI 48501

- Electronic submission:
  Hoosier Healthwise EDI: 3519M
  Healthy Indiana Plan EDI: 3135M

Claims

Claim Submission

- Online through the Provider Portal
- Electronic submission:

  Electronic Payer ID: 68069
- Paper claims:

  Managed Health Services
  P.O. Box 3002
  Farmington, MO 63640-3802

Claims

Claim Submission for Behavioral Health

- Online through the Provider Portal
- Electronic submission:

  Behavioral Health Payer ID: 68068
- Paper claims:

  Managed Health Services
  P.O. Box 6800
  Farmington, MO 63640-3818

Claims

Claim Acceptance & Adjudication (applies to all MCEs)

- System reviews claim for errors and critical fields (i.e. dates of service, billing/rendering provider, etc.) prior to acceptance.
- Regulatory requirements (federal and state) mandates certain information to be present in order to accept and pay a claim.
- NPI common rejection/denial; provider information on claim **must** match record at State – a State requirement. (SAPI)
- Depending on services or claim components, claim may need to be manually processed by claims processor.

Claims

Claim Rejection

- Rejected claims – Claims with invalid or missing information that are rejected prior to entering into the claims system
- Rejected claims may be corrected and resubmitted.
- Examples of rejected claims*
  - Provider/practitioner not enrolled in IHCP
  - Invalid member RID number
  - Incorrect type of bill for the service or location
  - Missing or invalid modifier

*Anthem does not reject claims with missing information; instead claims are processed in the system and if information is missing or incorrect, the claim is denied.

Claims

Claim Denial

- Largest single sources of claim denials include:
  - NPI
  - Timely filing
  - Prior authorization
  - Duplicate claim
  - Service not covered
- Denied claims can be disputed and/or appealed by providers.

Claims

Anthem BlueCross BlueShield

Top 5 Claim Denials for 2019 (Anthem now hosts monthly webinars on the third Friday of each month to provide updates)

Professional Claims:

- Billing NPI Denials Z33
- Duplicate Submission 346, CDD, GD0, i56, WIN, Y38
- Deny PA Not Obtained Y3Z, Y40, Y41, YAJ
- Submitted after plan filing limit TF0, TF1, X15, X16
- Services not eligible for this provider (This denial pertains to the Methadone Treatment Centers) GC9

Facility Claims:

- Submitted after plan filing limit TF0, TF1, X15, X16
- Duplicate Submission 346, CDD, GD0, i56, WIN, Y38
- Billing NPI Denials Z33
- Attending NPI Denials Z28, Z32
- Deny PA Not Obtained Y3Z, Y40, Y41, YAJ

Claims

CareSource

Top 5 Claim Denials for 2019

Professional claims:

- Service requires authorization (131/270/3E1/4E1/X94/ZF7)
- Not a covered service (4GB)
- Incomplete/invalid rendering provider NPI (KNP/OR7)
- Invalid or missing claim line/data (p03)
- Procedure has an unbundle relationship (z58/z76/z77)

Facility claims:

- Service not payable for provider (9NP/9PS/9SD/XPS/Z23)
- Invalid or missing claim/line data (p03)
- Invalid procedure code (N13/XNC/e03)
- Procedure has an unbundle relationship (z58/z76/z77)
- Service requires authorization (3E1/8E1)

Claims

MDwise
A McLaren Company

Top 5 Claim Denials for 2019

Professional claims:

- Duplicate Claim/Service (18)
- W9 is required (272)
- Member has other insurance information – no EOB attached to claim (22)
- Member not enrolled with health plan – unknown member assigned to claim (177)
- Payment denied for absence of authorization or exceeds authorization units (197)

Facility Claims:

- Duplicate Claim/Service (18)
- Claim requires valid condition code (16)
- Other insurance payments must be reported at the claim line level to be considered (16)
- Member has other insurance information – no EOB attached to claim (22)
- Service is not reimbursable for this provider (96)

Claims

Top 5 Claim Denials for 2019

1. Time Limit For Filing Has Expired (EX29)
2. Bill Primary Insurer 1st (EXL6)
3. Authorization Not On File (EXA1)
4. Denied After Review of Patients Claim History (EXya)
5. Invalid or missing modifier (EXIM)

Additional Information for Denial Codes can be found using this link
https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/0917-OS-P-WM-EX-Code-Descriptions-MHS-Denial-Codes-11-17-2017.pdf

Claims

Claim Adjustment (applies to all MCE's)

- A corrected claim can be submitted following IHCP claim adjustment processes.
- A claim adjustment code is required on all claims, based on the type of claim submitted.
  - Example: Frequency 7 entered in Box 22 of the CMS 1500 form.
  - Example: Frequency 7 used as the last digit for the bill type on a UB04 form (i.e. 1x7)
- The original claim number must also be listed on the corrected claim.
  - Box 22 on the CMS 1500 and box 64 on the UB04.
- Handwriting or stamping on a claim will not be accepted as submission of a corrected claim.

Claims

Claims disputes must be:

- Filed within 60-calendar days from the date on the remittance (MHS allows 67 days)
- Submitted in writing (Anthem takes verbally/Availity, CareSource can be done via portal) – add submission information
- Completed prior to requesting an appeal

Note:

- Disputes that are not filed within the defined time frames will be denied without a review for merit.
- Disputes are available for participating and non-participating providers

Claims

Claims appeals must be:

- Be filed after the dispute decision.
- While FFS requires filing within 15 days of the date of dispute determination, Anthem allows 30 days and CareSource, MDwise allows 60 days and MHS allow 67 days.

Appeals will be resolved within 45 calendar days from the date of the receipt of the appeal.

All appeal decisions are final.

Claims

Anthem BlueCross BlueShield

Claim Disputes/Appeals

- Submit disputes electronically at www.availity.com, through provider services*.
- Mail: Anthem Blue Cross and Blue Shield
  Provider Disputes and Appeals
  P.O. Box 61599
  Virginia Beach, VA 23466
  (this address includes 2nd level administrative appeals)
- Fax: 1-855-535-7445

*Electronic submission not available for appeals.

Claims

CareSource

Claim Disputes/Appeals

- Electronically on the CareSource Provider Portal
- Mail:
  CareSource
  Attn: Health Partner Appeals
  P.O. Box 2008
  Dayton, OH 45402
  Fax: 844-417-6262
- If you believe the claim was processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim.
- Claim Dispute form: https://www.caresource.com/documents/claims-dispute-form-in-med-provider/

Claims

MDwise
A McLaren Company

Claim Dispute (in order of process)

- Call the Provider Customer Service Unit (PCSU): 1-833-654-9192
- Submit the Claim Adjustment Request Form
- Dispute the claim by emailing the form to cdticket@mdwise.org or mailing to:

  MDwise
  P.O. Box 441423
  Indianapolis, IN 46244-1423
  Attn: Disputes

Claims

Claim Disputes/Appeals

- Filing information found in the MHS Provider Manual
- Level One Appeal: Must be made in writing by using the MHS informal claim dispute/objection form, available at www.mhsindiana.com/provider-forms.
- Send to MHS within 67 calendar days of receipt of the MHS explanation of payment (EOP). Please reference the original claim number. Requests received after day 67 will not be considered.
- Submit all documentation supporting your objection to:

  Managed Health Services
  Attn: Appeals
  P.O. Box 3000
  Farmington, MO 63640-3800

Claims

Claim Disputes/Appeals

- Filing information found in the MHS Provider Manual
- Level Two Appeal: If you disagree with your level one decision, submit the informal claims dispute or objection form with all supporting documentation to the MHS appeals address:
- Managed Health Services
  Attn: Appeals
  P.O. Box 3000
  Farmington, MO 63640-3800
- To follow up on your dispute or appeal submission, please call 1-877-647-4848.

Claims

Claim Disputes/Appeals

- Arbitration:
  - To initiate arbitration, the provider should submit a written request to MHS on company letterhead.
  - The request must be postmarked no later than 60 calendar days after the date the provider received MHS' decision on the administrative claim appeal.
  - The letter should explain arbitration is being requested, the reason the provider still believes the claims should be paid or adjusted, along with sufficient information to allow MHS to identify the claims and verify they have been considered at both the dispute/objection and the appeal stage prior to the arbitration request.
- Send such requests to*:

MHS Arbitration
550 N. Meridian Street
Suite 101
Indianapolis, IN 46204

*unless otherwise directed in the letter

Provider Maintenance

Provider Maintenance

- It is the provider's responsibility to ensure that the enrollment information on file for that provider is complete and current, and to notify the IHCP and the MCE's of any changes.
- Not updating your information with each MCE could cause claim denials/rejections or provider termination.
- Providers must make changes with IHCP prior to making changes with the MCE's.
- Provider information updates include:
  - Address changes including mail-to, pay-to, service location or legal address
  - Tax Identification Number (TIN) changes
  - Provider specialty
  - Enrollment status (disenrollment requests)
  - Legal name or doing business as (DBA) name

Provider Maintenance

Anthem BlueCross BlueShield

- Provider information can be updated using the Provider Maintenance Form
- This form is for physicians, providers, professionals and ancillary providers to apply for participation with Anthem Blue Cross and Blue Shield in Indiana.
- This form can also be used for non-contracted providers who are interested in joining Anthem's network.
- Questions regarding this form?
  - Call: 1-800-455-6805

Provider Maintenance

CareSource

- Provider information can be updated using the Health Partner Change Request Form.
- Changes can also be submitted using the CareSource Provider Portal.
- Questions regarding this form?
  - Call: 1-844-607-2831

Provider Maintenance

- Provider information can be updated using one of the following forms:
  - Provider Update Form (for PMPs)
  - MCE Provider Enrollment/Update Form
- Questions regarding this form?
  - Call: 317-822-7300, extension 5800

Provider Maintenance

- Provider information can be updated using the Provider Demographic Update Tool.
- Questions regarding this form?
  - Call: 1-877-647-4848

Gateway to Work

Gateway to Work

Gateway to Work (GTW) is a part of the Healthy Indiana Plan (HIP). It connects HIP members with ways to look for work, train for jobs, finish school and volunteer. Starting in 2019, members may be required to do GTW activities to keep their HIP benefits.

- Family and Social Services Administration (FSSA) will assign a GTW status to all HIP members: reporting, reporting met or exempt.
- GTW members will be assessed at the end of each calendar year to determine if requirements were met for at least eight of the 12 months.

Gateway to Work

GTW statuses include:

- Exempt — The member meets an exemption for GTW. They are not required to participate during months they are exempt; however, exempt members can still participate in GTW optionally.
- Reporting met — The member does not meet an exemption, but already works at least 20 hours per week as reported to FSSA. The member does not need to do anything new for GTW unless they report a change of employment to FSSA.
- Reporting — The member is required to do GTW. They will have to work, attend classes or volunteer and report those activities each month through the FSSA Benefits Portal or their managed care entity (MCE).

Gateway to Work

GTW exemptions include:*

- Those deemed medically frail.
- Pregnant women.
- Members 60 years of age or older.
- Caregiver:
  - Of a dependent child under 7 years old.
  - Of a disabled dependent.
  - Of an abused of neglected child (Kinship Caregiver).
- Those with a certified temporary illness or incapacity
- TANF/SNAP recipients.
  - Homeless individuals.
  - Institutionalized/recently incarcerated individuals.
  - Those in active substance use disorder treatment.
  - Those Students (half or full-time).

* Other possible exemptions will be reviewed for good cause on a individual basis.

Gateway to Work

Qualifying activities include:

Work

- Employment
- Job search activities
- Education related to employment

Learn

- Adult/General education
- Job skills training
- Vocational education or training

Serve

- Volunteer work
- Community service/public service with any organization

Gateway to Work

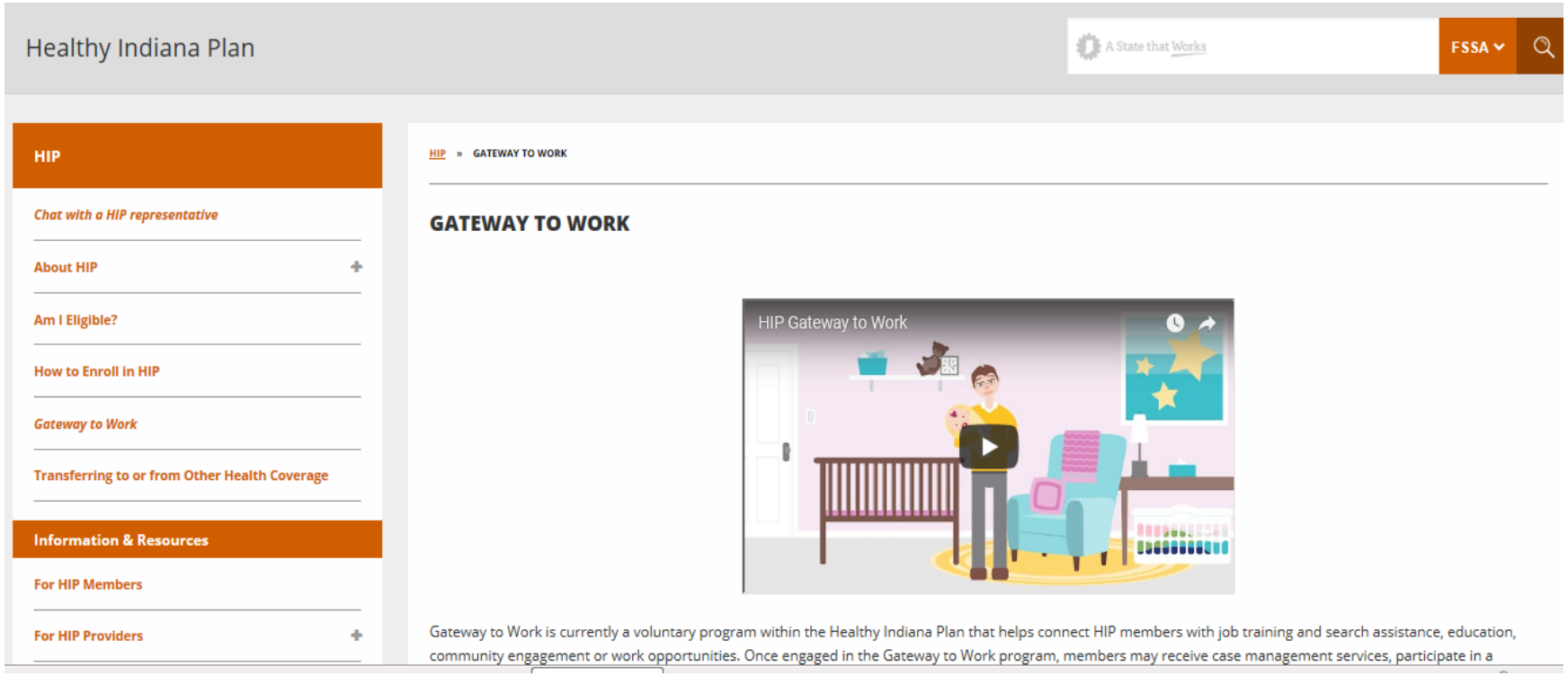
Hours phase-in begins January 2019:

- Required hours increase incrementally over 18 months to be fully implemented by July 1, 2020.
- Monthly hour requirement phase-in timeline:

Date	Required hours
January 1, 2019 – June 30, 2019	0 hours per month
July 1, 2019 – September 30, 2019	20 hours per month
October 1, 2019 – December 31, 2019	40 hours per month
January 1, 2020 – June 30, 2020	60 hours per month
July 1, 2020 – ongoing	80 hours per month

Gateway to Work

State developed website with information and member resources https://www.in.gov/fssa/hip/2466.htm.



Resources

Resources

IHCP Provider Reference Modules

- https://www.in.gov/medicaid/providers/810.htm

MCE Manuals

- Anthem: www.anthem.com/inmedicaid
- CareSource: https://www.caresource.com/documents/in-hip-hhw-health-partner-manual/
- MDwise: https://www.mdwise.org/for-providers/manual-and-overview
- MHS: https://www.mhsindiana.com/providers/resources/guides-and-manuals.html

Resources

Bulletins & Banners

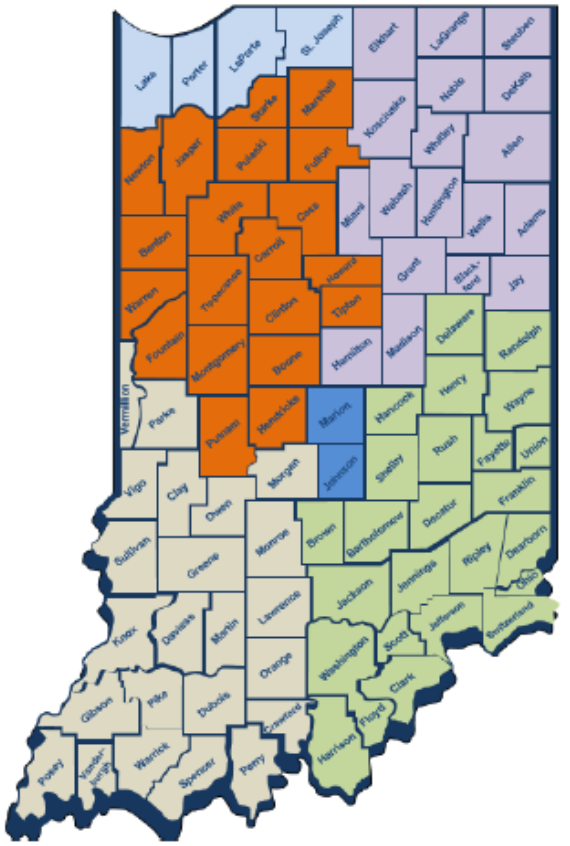
- IHCP: https://www.in.gov/medicaid/providers/737.htm
- Anthem: www.anthem.com/inmedicaid
- CareSource: https://www.caresource.com/in/providers/tools-resources/updates-announcements/medicaid/
- MDwise: https://www.mdwise.org/for-providers
- MHS: https://www.mhsindiana.com/providers/provider-news.html

Resources

Anthem BlueCross BlueShield

Network Relations — State of Indiana Territory Map

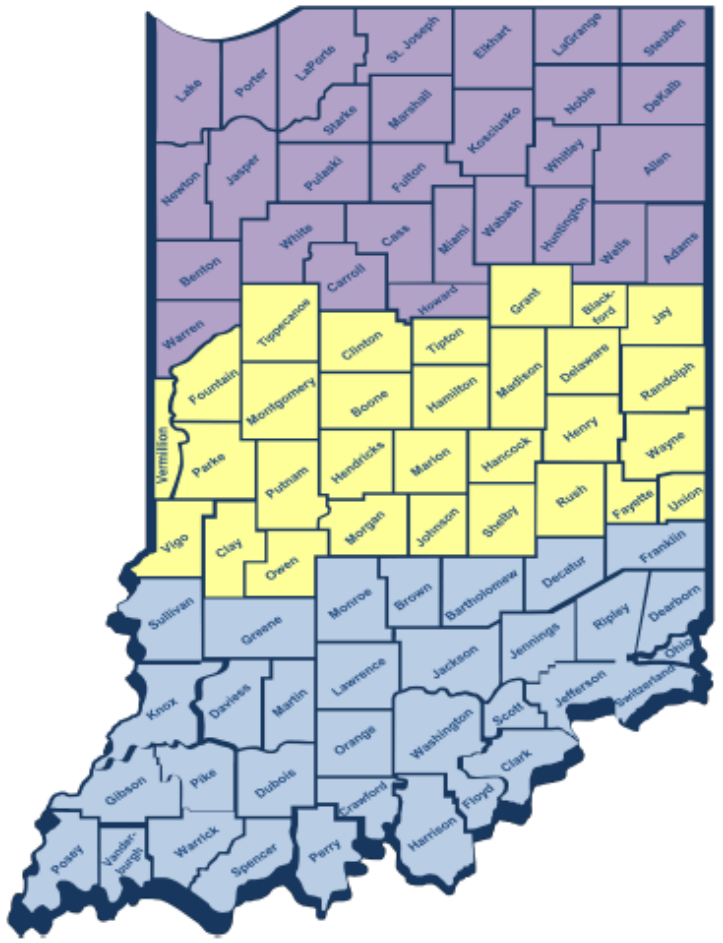
Northwest region/Franciscan	Northeast region/IU Health	Southwest region/Deaconess
Please send questions to askyournetworkrelations representative@anthem.com	Matt Swingendorf matthew.swingendorf@anthem.com 1-317-306-0077	Jonathan Hedrick jonathan.hedrick@anthem.com 1-317-601-9474
West Central region/St. Vincent	**Southeast region**	**Community health**
Angelique Jones angelique.jones@anthem.com 1-317-619-9241	Sophia Brown sophia.brown@anthem.com 1-317-775-9528	Ron Gibson, Network Support Manager rondinel.gibson@anthem.com 1-317-287-6429
Central region		
Marvin Davis marvin.davis@anthem.com 1-317-501-7251 Marion County: 46280, 46240, 46250, 46256, 46236, 46216, 46235, 46229, 46220, 46205, 46226, 46218, 46201, 46219, 46203, 46239, 46107, 46259, 46237, 46227, 46204 Johnson County: 46162 (Needham), 46124 (Edinburgh), 46184 (New Whiteland), 46131 (Franklin)	Tina Mason tina.mason@anthem.com 1-463-201-3718 Marion County: 46290, 46260, 46268, 46278, 46254, 46228, 46208, 46202, 46222, 46224, 46214, 46234, 46221, 46225, 46217, 46221, 46241, 46231, 46183, 46113 Johnson County: 46106 (Bargersville), 46181 (Trafalgar), 46142 and 46143 (Greenwood), 46164 (Nineveh)	
Out-of-state providers		
Nicole Bouye nicole.bouye@anthem.com 1-317-517-8862		
Indiana provider Network Solutions		
1-800-455-6805		



Resources

Anthem BlueCross BlueShield

Provider Network Relations
Behavioral Health



Michele Weaver
1-317-601-3031
Michele.Weaver@anthem.com

Alisa Phillips
1-317-517-1008
Alisa.Phillips@anthem.com

Matthew McGarry
1-463-202-3579
Matthew.McGarry@anthem.com

Behavioral Health Relations Team:
anthembehavioral@anthem.com

Provider Network Relations
Behavioral Health
State of Indiana

Resources

CareSource

Leadership

Denise Edick, Manager, Health Partnerships
317-361-5872
Denise.Edick@caresource.com

Amy Williams, Team Lead, Health Partnerships
317-741-3347
Amy.Williams@caresource.com

Behavioral Health

Angelina Warren, Behavioral Health Partner Engagement Specialist
317-658-4904
Angelina.Warren@caresource.com

Associations & Dental

Brian Grcevich, Ancillary, Associations and Dental
317-296-0519
Brian.Grcevich@caresource.com

Contracting Managers – Hospitals/Large Health Systems

Tenise Hill – North
317-220-0861
Terise.Hill@caresource.com

Mandy Bratton – South
317-209-4404
Mandy.Bratton@caresource.com

Regional Representatives

Sylvia Vargas
219-713-7775
Sylvia.Vargas@caresource.com
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260-403-8657
Catherine.Pollick@caresource.com
Parkview, Lutheran

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219-214-3950
Tonya.Thompscn2@caresource.com
Union Hospital, American Health Network

Maria Crawford
317-416-6851
Maria.Crawford@caresource.com
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765-993-7118
Jennifer.Little@caresource.com
Community Health Network, Eskenazi

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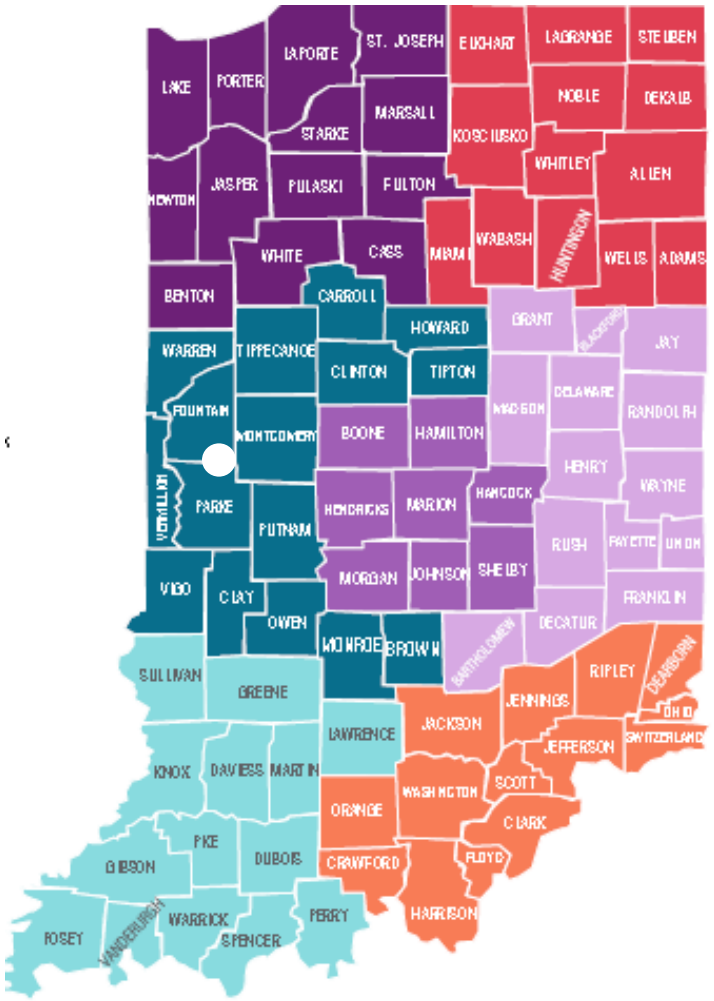
812-454-5832
Bonnie.Waelde@caresource.com
Deaconess & St. Vincent Health

Paula Garrett
812-447-6661
Paula.Garrett@caresource.com
KentuckyOne, Norton, Baptist Health Floyd



Resources

MDwise
A McLaren Company

Region 1
Paulette Means
pmeans@mdwise.org
317-822-7490

Region 2
Jinny Hibbert (Interim)
jhibbert@mdwise.org
317-822-7300 ext. 5800

Region 3
Michelle Phillips
mphillips@mdwise.org
317-983-7819
(Home Health & Hospice)

Region 4
Jamaal Wade
jwade@mdwise.org
317-822-7276

Region 5
David Hoover
dhoover@mdwise.org
317-983-7823

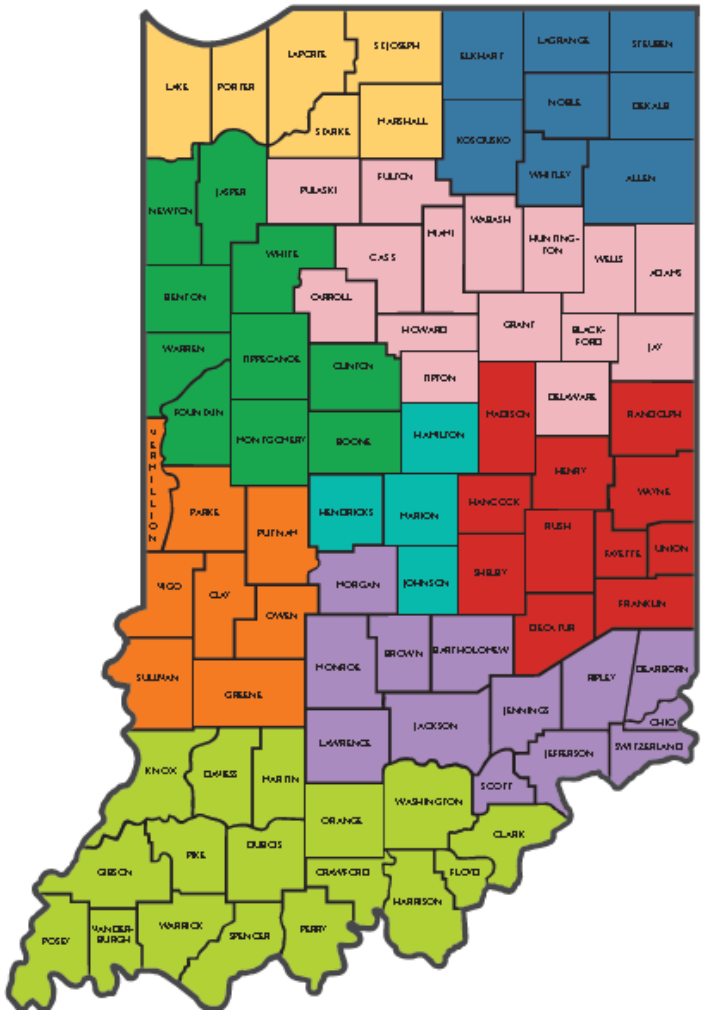
Region 6
Tonya Trout
ttrout@mdwise.org
317-308-7329

Region 7
Rebecca Church
rchurch@mdwise.org
317-308-7371

Region 8
Sean O'Brien
sobrien@mdwise.org
317-308-7344

Region 9
Whitney Burnes
wburnes@mdwise.org
317-308-7345

Nichole Young, RN
nyoung@mdwise.org
317-822-7509
(Behavioral Health - CMHCs, OTPs, MDs, Residential)



Resources

Territory Map

NORTHEAST REGION

Claims Issues: MHS_ProviderRelations_NE@mhsindiana.com
Chad Pratt, Provider Partnership Associate
1-877-647-4848 ext. 20454
ripratt@mhsindiana.com

CENTRAL REGION

Claims Issues: MHS_ProviderRelations_C@mhsindiana.com
Esther Cervantes, Provider Partnership Associate
1-877-647-4848 ext. 20947
Estherling.A.PimentalCervantes@mhsindiana.com

NORTHWEST REGION

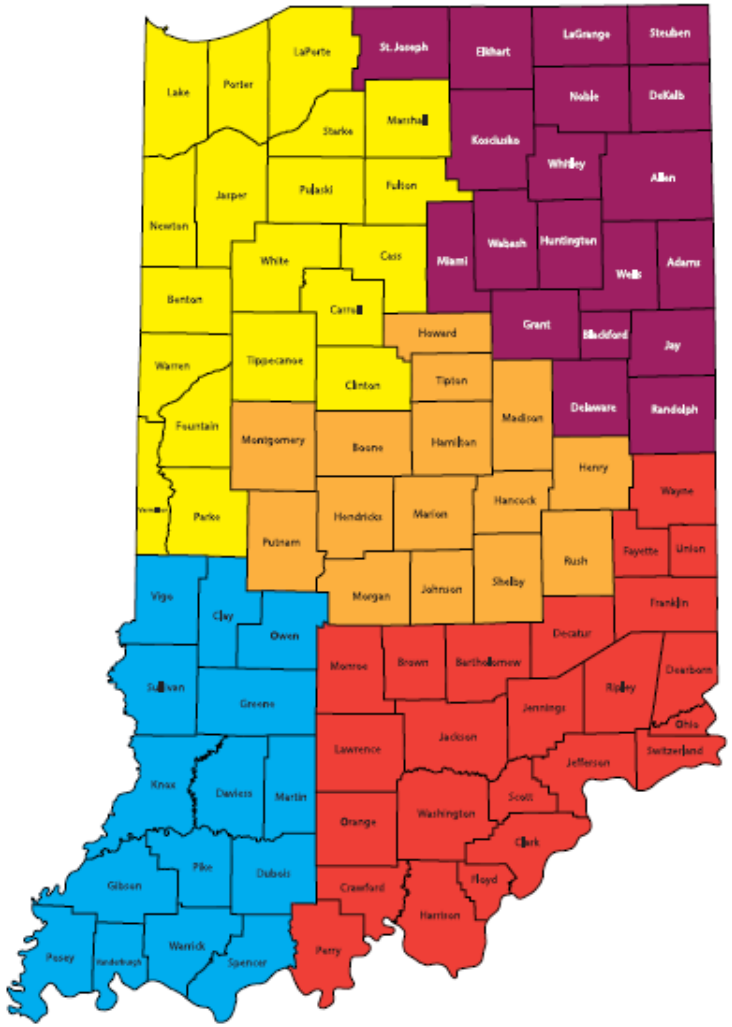
Claims Issues: MHS_ProviderRelations_NW@mhsindiana.com
Candace Ervin, Provider Partnership Associate
1-877-647-4848 ext. 20187
Candace.V.Ervin@mhsindiana.com

SOUTHWEST REGION

Claims Issues: MHS_ProviderRelations_SW@mhsindiana.com
Dawn McCarty, Provider Partnership Associate
1-877-647-4848 ext. 20117
Dawnalee.A.McCarty@mhsindiana.com

SOUTHEAST REGION

Claims Issues: MHS_ProviderRelations_SE@mhsindiana.com
Kat Gibson, Provider Partnership Associate
1-877-647-4848 ext. 20959
kagibson@mhsindiana.com



Resources

Territory Map

TAWANNA DANZIE
Provider Partnership Associate II
1-877-647-4848 ext. 20022
tdanzie@mhsindiana.com

PROVIDER GROUPS
Beacon Medical Group
Community Care Network
Franciscan Alliance
Goshen Health System
HealthLinc
Heart City Health Center
Indiana Health Centers
Lutheran Medical Group
Northshore Health Centers
Parkview Health System
South Bend Clinic

JENNIFER GARNER
Provider Partnership Associate II
1-877-647-4848 ext. 20149
jgarner@mhsindiana.com

PROVIDER GROUPS
American Health Network of Indiana
Columbus Regional Health
Community Physicians of Indiana
Good Samaritan Hospital Physician Services
HealthNet
Health & Hospital Corporation of Marion County
Indiana University Health
Little Company of Mary Hospital of Indiana
Riverview Hospital
St. Vincent Medical Group

INTERNAL REPRESENTATIVES

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LAKISHA BROWDER
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ENVOLVE DENTAL, INC.

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Dental Provider Services: 1-855-609-5157
Kara.Wilson@EnvolveHealth.com

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Mark Vonderheit
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mvonderheit@mhsindiana.com

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NEW PROVIDER CONTRACTING

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tbalko@mhsindiana.com

Michael Funk
Manager, Network Development & Contracting
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michael.j.funk@mhsindiana.com


Anthem
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CareSource

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mhs

Thank You!